Health and Human Services Transformation Panel

Morning Learning Session

Meeting Summary

February 27, 2013
9:00 a.m. - 12:00 p.m.
Mercer Island Community and Event Center

Panel Member Attendees:
Heidi Albritton, Seattle Human Services
Elizabeth Bennett, Seattle Children's Hospital
Dan Murphy on behalf of Jane Beyer, Washington State Department of Social and Health Services
Jim Blanchard, Auburn Youth Resources
Colleen Brandt-Schluter, City of SeaTac, Human Services
Shelley Cooper-Ashford, Center for Multicultural health
Merril Cousin, King County Coalition Against Domestic Violence
Doreen Booth on behalf of Deanna Dawson, Sound Cities Association
David Downing, Youth Eastside Services
Bill Hallerman, Catholic Community Services
Dr. Jeff Harris, Health Promotion Research Center
Patricia Hayden, Seattle-King-Snohomish YWCA
Ron Jackson, Evergreen Treatment Services (Ret)
Sharyne Shiu-Thornton on behalf of Hyeok Kim, International Community Development Association
Brian Knowles, Bailey Boushay House
Colleen Kelly on behalf of Emily Leslie, City of Bellevue
Elise Chayet on behalf of Dr. Dan Lessler, Harborview Medical Center
Sara Levin, United Way of King County
Julie Lindberg, Molina Healthcare of Washington
Marilyn Mason-Plunkett, Hopelink
Mark Okazaki, Neighborhood House
Nathan Phillips, South King Council on Human Services
Terry Pottmeyer, Friends of Youth
Adrienne Quinn, Medina Foundation
Kelly Rider, Housing Development Consortium
Mark Secord, Neighborcare

Diane Sosne, SEIU
Janet St. Clair, Asian Counseling and Referral Service
Margaret-Lee Thompson, Developmental Disabilities

Excused Panel Members:
Lisa Cohen, Washington Global Health Alliance

Community Stakeholder Attendees
Donna Allis, PHSKC
Graydon Andrus, DESC
Liz Anjur, Department of Health and Human Service
Rosemary Aragon, Pacific Hospital Preservation & Development Authority
Trish Blanchard, Sound Mental Health
Shannon Braddock, King County Council Staff
Susie Bridges Weber, KC Superior Court
Gretchen Bruce, King County Department of Community and Human Services
David Budd, Full Life Care
Kathy Burgoyne, Community Health Education Foundation
Abie Castillo, CHPW
Carrie Cihak, King County Executive's Office
Susie Dade, Puget Sound Health Alliance
Jerry DeGrieck, City of Seattle
Jennifer DeYoung, PHSKC
Cindy Domingo, King County Council Staff
Alison Eisinger, Seattle/King County Coalition on Homelessness
Jesse Eller, City of Seattle
Larry Evans, King County Council Staff
Terri Flaherty, King County
David Fleming, PHSKC
Beratta Gomillion, Center for Human Services
Erin Hafer, CHPW
Sherry Hamilton, King County Department of Community and Human Services
Annette Holland, PHSKC
Kristin Houser, King County Mental Health Board
Kristin Hull, Mercy Housing NW
Jason Johnson, City of Kent
Matt King, YWCA
LorieAnn Larson, Sound Mental Health
Maureen Linehan, Seattle Human Services Aging and Disability Services
Courtney Madsen, International Rescue Committee
Linda Madsen, Community Health Council
Daniel Malone, DESC
Nicole Mari, DESC
Terry Mark, King County Department of Community and Human Services
Cheryl Markham, King County Department of Community and Human Services
Ross Marzolf, King County Council Staff
AJ McClure, King County Council Staff

Karen McEwen, DSHS
Leslie Miles, King County
Katy Miller, King County Department of Community and Human Services
Sunshine Monastrial, International Community Health Services
Mike Nielsen, CPC
Erika Nuerenberg, PHSKC
Suzanne Pak, Immersion Force
Annya Pintak, Global to Local
Mark Putnam, Building Changes
June Robinson, PHSKC
Jerry Scott, Navos
Sue Sherbrooke, YWCA
Kathleen Southwick, Crisis Clinic
Karen Spoelan, KCRSON
Julia Sterkovsky, SHS Coalition
Doug Stevenson, United Way of King County
David Stone, Sound Mental Health
Adam Taylor, PHSKC
Kenneth Taylor, Valley Cities
Debbie Thiele, CSH
Carrie Vanzant, Sea Mar Community Health Center
Elizabeth Westburg, KCHA
Bill Wilson, King County Department of Community and Human Services
Carol Wood, United Way of King County
Linda Woodall, United Way of King County
Declan Wynne, Sound Mental Health
Andrea Yip, Seattle Human Services

I. Welcome, Introductions, Agenda Overview

Judy Clegg welcomed attendees and introductions were given. Panel members were asked to stand and recognize themselves. Biographies for panel members were included in the handout materials. Judy introduced Pat Jones from Vermont and Robin Henderson from Oregon as the guest speakers of the day. Kelli Caroll introduced Councilmembers Julia Patterson and Joe McDermott.

II. Opening Remarks

Councilmember Julia Patterson thanked both our guests and panel members for their contribution and the information that will be dispersed today regarding health and human services. She recognized that there is an opportunity to integrate services and leverage resources. The goal is to design a system in which we can be held accountable while analyzing the needs of individuals. Discussions have to take place in order to find out if systems are working together to achieve maximum efficiencies. The costs of the work pale in comparison to not doing it. King County is both a compassionate people as well as a wealthy people. We do not want to live in a community that provides great opportunity for wealth for a few people creating a large disparity. Councilmember Patterson thanked the participants.

Councilmember Joe McDermott noted that he is pleased with the efforts of those involved in this endeavor. Making community service funding a priority is important. The effects of budget cuts have decimated community service budgets. The diminished funding is the new norm. This is why it is important to leverage funding. It is for both constituents and clients. Obama Care will help improve health outcomes and prove unprecedented opportunities to remove silos. This work will help fund the future and the growing needs of our neighbors and communities.

III. Historical Context for our Transformation Work

Judy Clegg gave a historical context for the transformation work being done and recognized the many collaborative efforts over the years. Alignment is taking place between councils, communities, and all levels of government presenting a window of opportunity to build upon the discoveries that have been made over time. The Affordable Care Act offers an incredible opportunity to bring about the transformation supported by the King County motion and all of the participants in attendance. Judy encouraged participants to ensure that as a group they from the past and take advantage of this enormous opportunity.

Dale Jarvis addressed the audience. He has been working on health reform projects in 21 states. The dream for this session was to have those from other states that have the most interesting things going on come and relay their systems workings and successes.

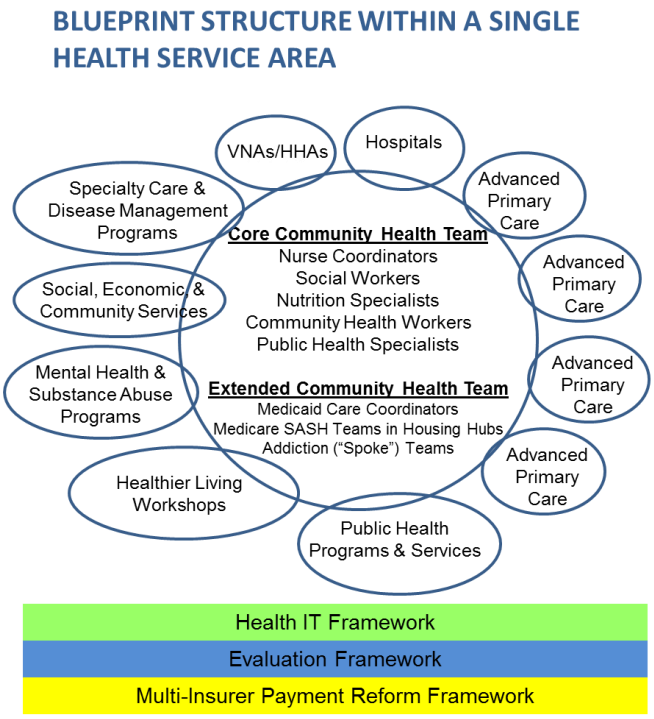
System Transformation in Vermont and Bend: Overview Presentations and Q&A by Pat Jones and Robin Henderson

Pat Jones

Pat introduced herself and then noted that attendees are doing the hardest part by getting together as a group to begin the process. She then began her presentation, which is outlined below, drawing from Pat's slides. Additions to the slides as well as Q&A are noted ***in bold italic.***

- Overview of the Blueprint Model
- Background
    - Vermont has about the same population as Seattle
    - The blueprint is overarching state framework, rolled out at the local level,
    - VT has just three major commercial insurers covering the commercial market, with CMS, so payment reform covers 5 carriers
        - 2003 Blueprint launched as Governor's initiative
        - 2005 Implementation of Chronic Care Model
        - 2006 Blueprint codified as part of sweeping reform legislation (Act 191)
        - 2007 Blueprint leadership and pilots established (Act 71)
        - 2008 Community Health Team structure and insurer mandate codified (Act 204)
        - 2010 Statewide expansion of Blueprint outlined (Act 128)
        - 2011 Planning for "Single Payer" (Act 48)
        - 2012 Refinement of Health Insurance Exchange and statewide reforms

- Blueprint Framework
  - Advanced Primary Care Practices (Patient Centered Medical Homes)
  - Practice Facilitators (assist with preparation for NCQA scoring and ongoing quality improvement)
  - Community Health Teams (core teams and extenders)
  - Self-Management Programs (Healthier Living, Tobacco Cessation, Diabetes Prevention, Wellness Recovery)
  - Multi-Insurer Payment Reforms
  - Health Information Technology Infrastructure
  - Evaluation and Reporting Systems
    - Learning Health and Human Services System Activities
      - Taking experiences and data across communities to continuously improve care



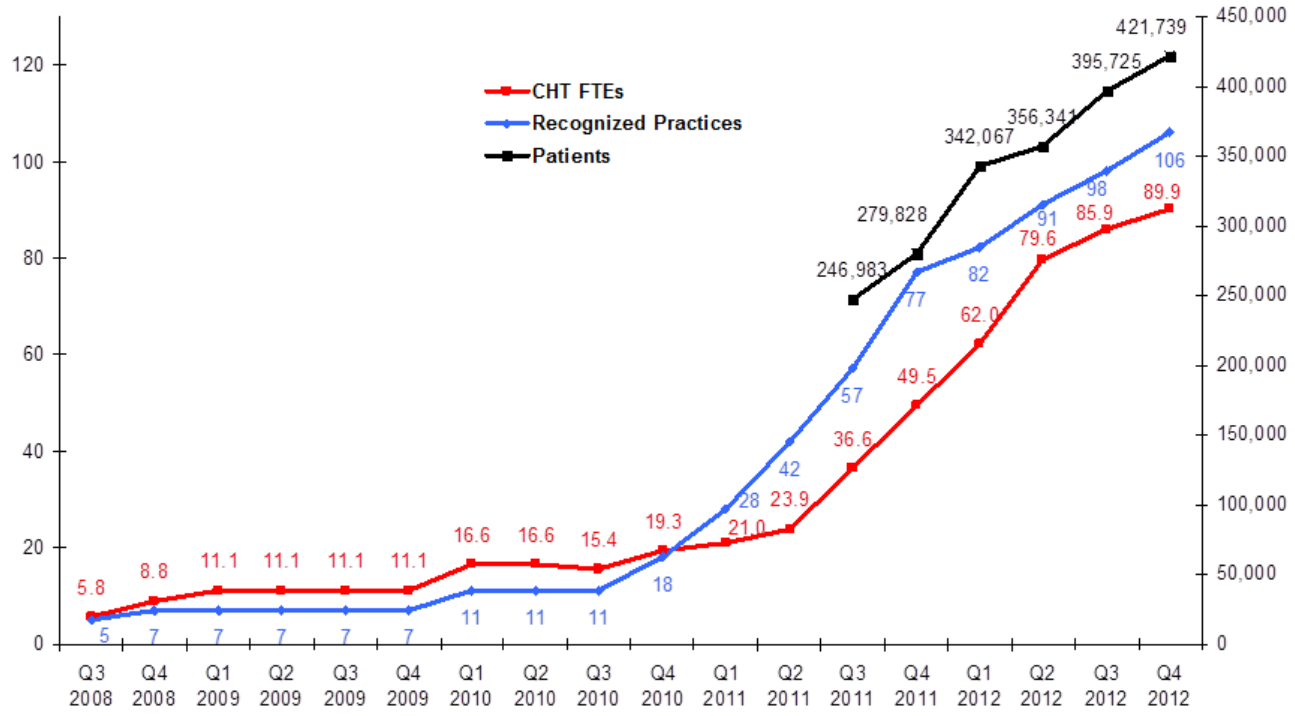
- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi-insurer payment reform that supports this foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

8

Goals – The Triple Aim

- Health care cost control
- Improved health outcomes
- Enhanced patient and provider experience
- Barrier-free access to services
- Reliable information sharing

- Blueprint Evolution
  - Started as a multi-stakeholder working group focused on the "Sickest Ten Percent" (10% of the population using 80% of the resources). ***Early on they did not have the human services folks at the table.***
  - A key inspiration was the Chronic Care Model, based on the work of Dr. Ed Wagner from Group Health.
  - Evolved into current model of comprehensive health delivery system reform, including care for the chronically ill.



  - Continue to evolve
    - Expand number of practices, CHT staffing, number of SASH teams, and payment reforms (scale and scope) ***Challenge is the small 1-2 doc practices***
    - Continue building IT infrastructure; improve reliability of reporting
    - Continue building evaluation infrastructure
    - Continue building Learning Health System infrastructure, including Multi-State Learning Health System
    - Enhance integration with other services (mental health, substance abuse, specialty care, social and economic services)
  - Payment Reforms

Questions

Q: Is the blueprint something that just goes on a shelf?

- ***No – it's a constantly evolving process based on looking at patient needs and planning together with everyone at the table to meet the gaps in care. The state also evaluates to see what's not working – like HI,T which has now become a major focus.***

Q: Please say a bit more on how you are attempting to solve the HIT issue? Are you moving to the same platform? Establishing Standards?

- ***Not all practices are using the same EHR. Some practices are still using paper. In fact, there are 15 different EHRs in use, but VT has established a clinical registry where even the paper practices enter information, or an EHR can feed data into the system.***
- ***VT found that clinicians were not getting actionable data from the systems. Since part of the key to reform is that providers are getting what they need to improve care for patients, this was a big problem. As a result, VT has established rapid response teams to sprint through every single data entry issue when a practice is having problems. These teams work with providers to rapidly resolve the issue***

Q: Please talk more about integration with non-medical services. Is this limited to community health teams?

- ***The CHTs pull all of the service providers together to engage in care. The thought is that the CHTs are staffed based on local decisions. There is a CHT extension program for people getting medication assistance treatment. Nurses and mental health and substance abuse professionals are being sent out to help provide services. There is no state level dictate of what staffing and services to provide. These are local decisions to plan and meet gaps in care. The goal is to keep the program flexible***

Q: In other locations where carriers have paid for teams and care coordinators there have been issues of trust – has that been an issue?

- ***VT does not have care managers paid by carriers***
- ***No, there is not distrust, practices love the practice coordinators. There was some distrust, but it has abated by bringing people together***

Q: How does the area agency on aging fit in to this model?

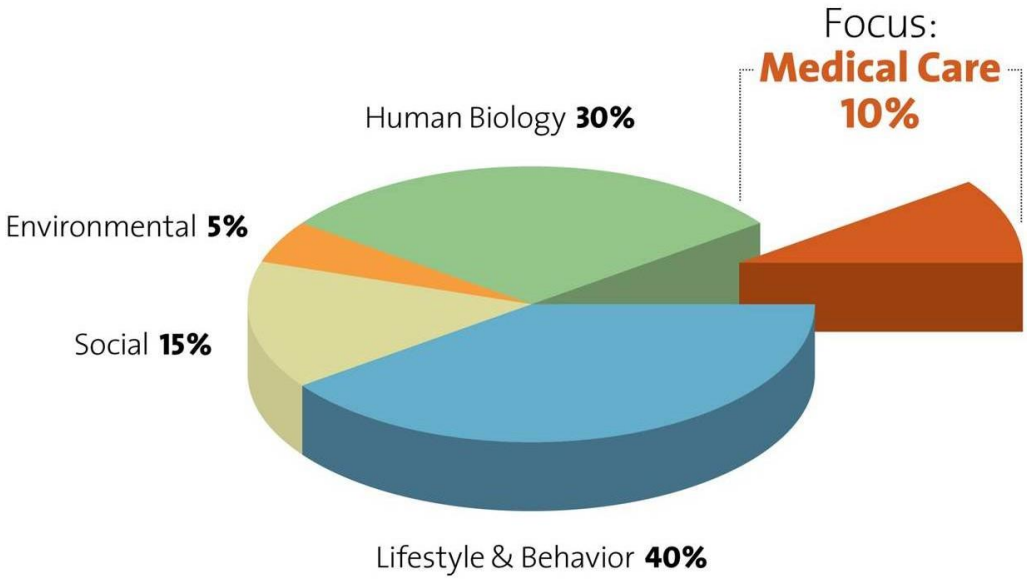
- ***They are included and in addition there is another extender program (SASH).***
- ***Support and Services at Home (SASH) is another program geared at Medicare beneficiaries. Starting to work with them to evaluate their services statewide, with goal to flag the people they are working with to show the impact of their services on the population.***

Robin Henderson

Robin introduced herself and then summarized what her talk would cover. Specifically, what are Coordinated Care Organizations (CCO) and why and how are CCOs being created?

- Why? Unsustainable -- Healthcare cost began to overshadow the other budget needs.
  - Health care costs are increasingly unaffordable to individuals, businesses, the state and local governments
  - Inefficient healthcare systems bring unnecessary costs to taxpayers
  - When budgets are cut, services are slashed

- Dollars from education, children's services, public safety
- 2014: as many as 200,000 Oregonians will be added to OHP



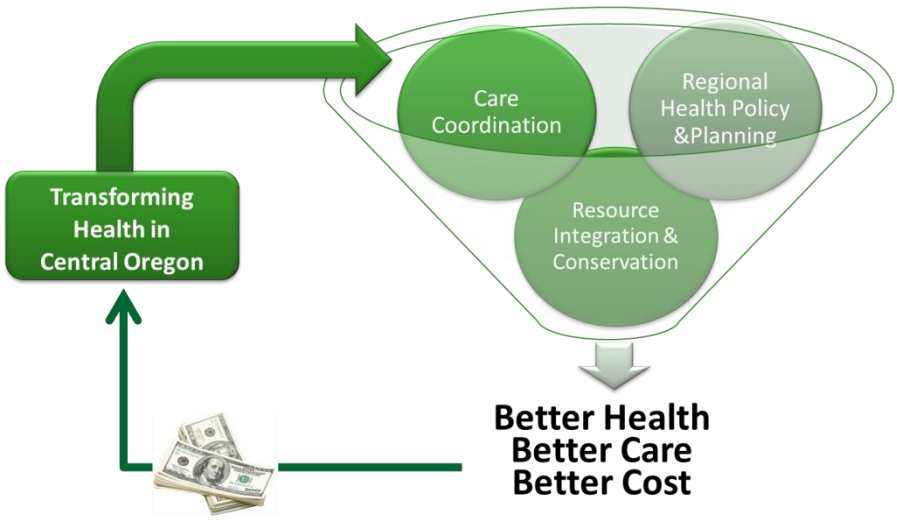
- During 2011 and 2012 legislative session Governor Kitzhaber and bi-partisan lawmakers passed landmark legislation for healthcare reform
- 200 people met in Governor appointed work groups to help create the framework for CCOs
- More than 1,200 Oregonians provided input through eight community meetings that were held around the state

- How
  - During 2011 and 2012 legislative session Governor Kitzhaber and bi-partisan lawmakers passed landmark legislation for healthcare reform
  - 200 people met in Governor appointed work groups to help create the framework for CCOs
  - More than 1,200 Oregonians provided input through eight community meetings that were held around the state
  - SB 1580 became law in 2012, laying the foundation for CCO development with aggressive timelines
  - $1.9 billion in Federal funds over 5 years to support healthcare transformation efforts
  - Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years
  - Oregon will lower the cost curve by two percent over the next two years
- Who
  - 35,000 Medicaid (Oregon Health Plan) beneficiaries in Deschutes, Jefferson, Crook, and part of Northern Klamath and Lake counties, predicted to grow to 52,000 by 2019
  - 150 miles north to south
  - 200,000 residents, expected to grow to 250,000 by 2019

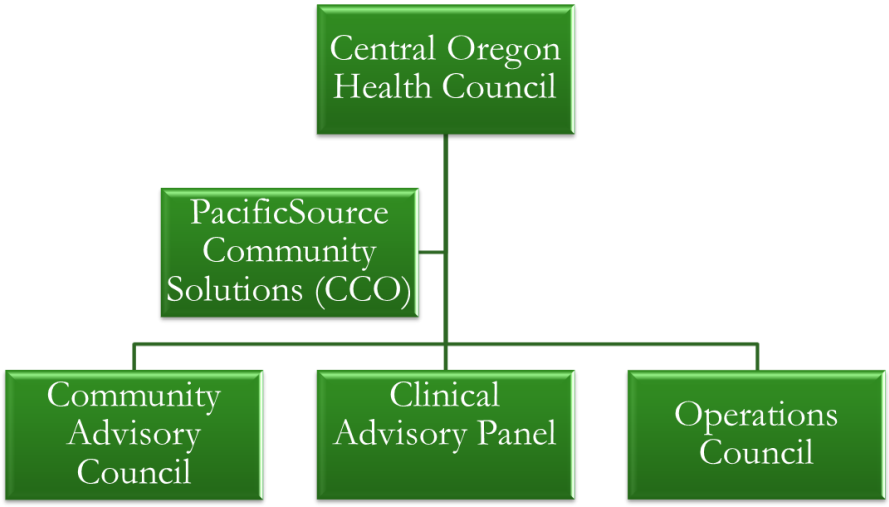
- Approximately $120m coming into the community
- Oregon Health Plan (Medicaid) beneficiaries only, in 2012
- Inclusion of additional State sponsored health benefits programs in the future (Public employees)
- Potential implications on non-Medicaid lines of business in Central Oregon

- Dream Team
  - Never doubt that a small group of thoughtful people can change the world. Indeed, it's the only thing that ever has.
  - The Triple Aim
    - Better health, better care, better cost
  - Central Oregon Health Council
    - Hospital, dental, FQHCs, multi-speciality (for profit)

The plan



Coordinated Care Organization



The COHC is the governance body of the CCO. The Councils of the COHC report to the COHC and are advisory to the CCO.

Roles and Responsibilities

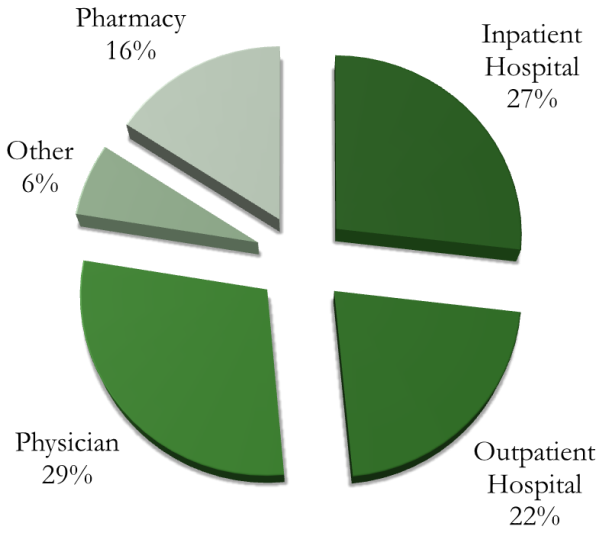
PacificSource Community Solutions	Central Oregon Health Council
• CCO fiscal and legal entity • Lead CCO operating entity • Managed care and TPA functions • Integration "hub" • Ensure work plan carried out for beneficiaries • Risk bearing entity • CCO contract holder with state • Contracts: downstream entities with core competencies	• Oversees CCO strategic and annual work plan • CCO performance metrics • Global budget framework • "Shared savings" principles • Transparency and accountability to community • Dispute resolution among stakeholders

CCO Joint Management Agreement

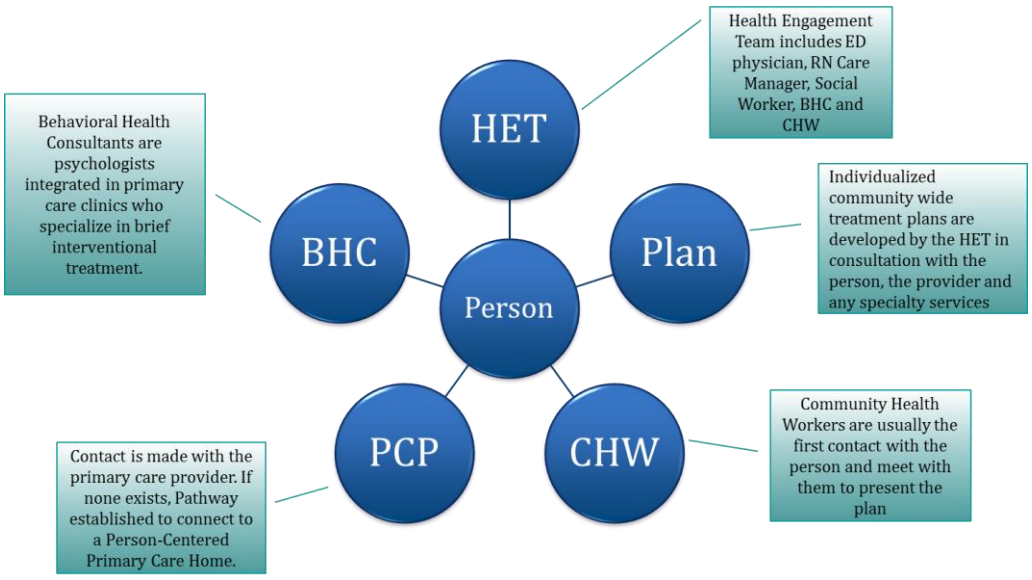
- CCO has a diverse operations council with each member having one vote. ***This is the hottest seat in town***:

CCO	Hospice	Primary Care
Critical Access Hospital	Indigent Care	Public Health Director--Crook
Education (K-12)	Long Term Care	Public Health Director--Jefferson
Health Services Director--Deschutes	Mental Health Director--Crook	Safety Net clinics (FQHC/RHC)
Health System	Mental Health Director--Jefferson & Chemical Dependency	Multi-Specialty Care
HIE/EHR	Oral Health	Warm Springs
Higher Education		

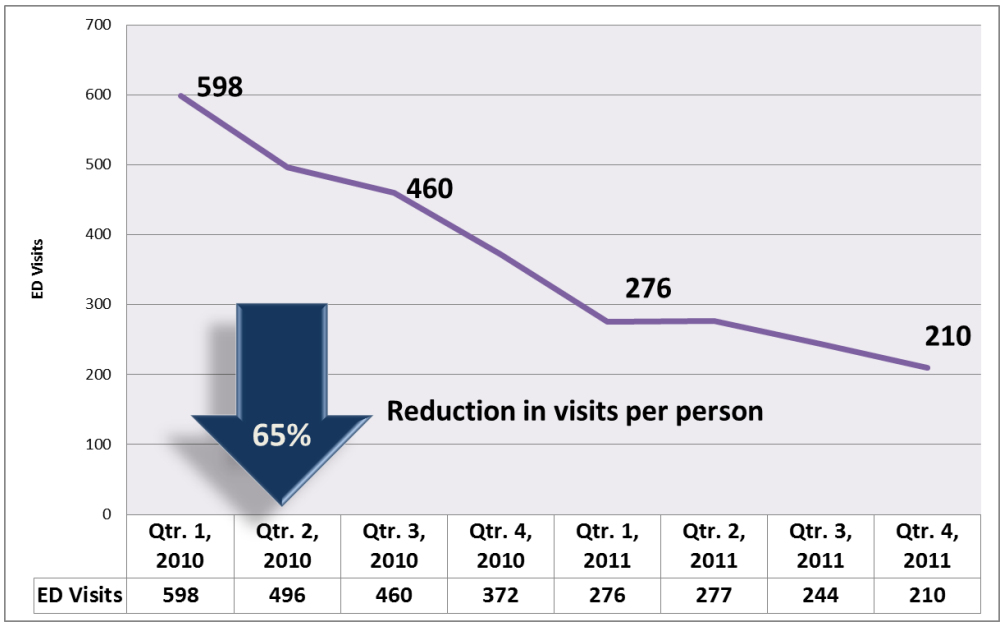
- How will CCOs achieve the health care Triple Aim?
  - Better care
  - Better health
  - Lower costs
- Structure of the CCO in Central Oregon and what entities are involved?
- Early Success
- Low Hanging Fruit



- Reduction Project focused on reducing non-emergent use of the Emergency Department in regional Emergency Department's using Health Engagement Teams, Behavioral Health Consultants and Community Health Workers
  - 274 Patients in the first cohort; over 700 identified participants to date
  - 144 of these actively identified needing intervention
  - Patients removed from study due to
  - Death
  - Relocation (moved, jail, etc.)
  - Data issues from the original pull



- Legislators like shiny, sparkly things….that finance real change
  - Has to be payor agnostic.
    - Everybody put money in for shared savings – 144 people, 313,116 invested, $356,985 RETURN
  - Emergency Department Visits per Quarter 2010-2011



  - We did this because we wanted to make our little corner of the world better

Questions

Q: Isn't Bend really a homogenous population, or is there diversity factored in

- ***Jefferson County is most diverse county in OR, with a high population of Latinos and Native Americans. This very diversity is a constant reminder of the need to have diversity at the table.***
- ***Brought in diversity at outset for Ops Council, as a conscious choice***
- ***One other key issue is "poverty with a view" – the many people who have economic struggles. You need to ensure you staff and address these issues***

Q: The pilot clearly had cost savings. Was there an improvement in health and behavior?

- ***We didn't withhold care, we engaged with patients to see how they experienced care. Goal was to connect patients with PCMHs, with patient and provider surveys to review success. People no longer felt judged, and felt they could talk to their doctors. Getting people to take ownership of their own care was a key piece***

Q: Where does a community health worker work? Do they just stay in the hospital?

- ***They work in the community. When we identify a person who is a high utilizer, we look at what the issue is and where we need to meet them. In fact, the CHW may not be the first point of contact. It is the person who makes the most sense to meet that person's needs.***

Q: Where does housing and homelessness fit in?

- ***It's a huge issue that we haven't addressed in a comprehensive enough way. Its part of what we do, but our connection to the homeless population is in development. So much of this happens organically, and when we started there were other issues, but they are now being addressed.***

Q: What about population mobility?

- ***Need to meet people where they are.***

Q: How does the whole range of human services fit in to this model?

- ***There aren't just four work groups. Rather, the Central Oregon Health Board is an offshoot of the Council and is part of all the things the counties are responsible for. We recognized that full integration was going to be a challenge, so this is a work in progress.***
- ***What has been most integrative has been the role of public health and its integration with primary care***

Q: Are 85% of OR providers willing to take Medicaid? That doesn't happen here. We have many issues with people not able to find providers.

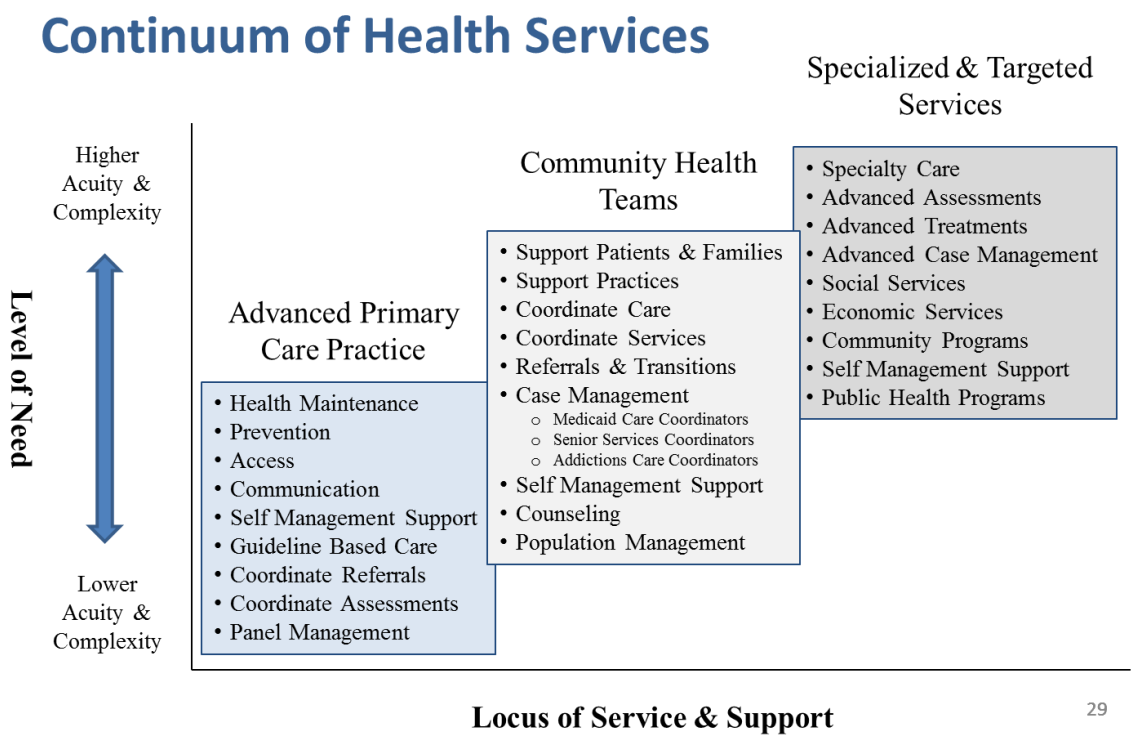
- ***Yes, they are <u>BUT</u> it is unclear how much Medicaid they take…***

Transformation in Vermont and Bend: System Designs Presentations by Pat Jones and Robin Henderson

Pat Jones

- IOM Definition of Team Based Care
  - Focus on Team-Based Care
    - Can't be done by one person alone,

        - 2011 NCQA Patient-Centered Medical Home Recognition Standards Support Team-Based Care
            - Enhance Access and Continuity
            - Identify and Manage Patient Populations
            - Plan and Manage Care
            - Provide Self-Care Support
            - Track and Coordinate Care
            - Measure and Improve Performance
    - Within the Practices - Characteristics of Advanced Primary Care Practices
        - Multi-disciplinary quality improvement team
        - (NCQA PCMH recognition)
        - Seamless coordination of care
        - (CHT development)
        - Information sharing through health IT
        - (Clinical Registry/Health Information Exchange interface)
    - Core Community Health Teams
        - Multi-disciplinary support for practices and their patients ***(and families)***
        - Working locally in communities and directly with all sizes and types of practices ***(teams are part of their communities)***
        - Functional integration into the practice setting – not just embedded, but fully functionally integrated even in the absence of physical colocation
        - Scaled based on number of patients in the HSA's practices
        - Core resource that is readily available to patients based on need ***– not COPAY***
        - 'Glue' in a community system of health and human services for the general population
    - Core CHT Key Activities
        - Provide interdisciplinary support for individuals
        - Coordinate referrals and services (medical and non-medical)
        - Assist practices with panel management and outreach
        - Improve the rate at which the general population receives recommended health assessments, adheres to preventive therapies, adopts effective self management skills, and engages in healthy lifestyles
        - Establish a continuum of services across sectors that are not always well integrated
            - Goal is to break down the walls. It is intense time consuming work. Success comes from hard work and fits and starts.
        - Develop relationships with primary care providers, practice staff, hospital discharge planners, specialists, community service providers, targeted case managers, and other functional CHT members



- Example CHT (100 FTEs around the state, with many new staff deployed)
  - Care Coordinators
  - CHT Managers
  - Social Workers
  - Mental Health/Substance Abuse Clinicians
  - Nutrition Specialists and Registered Dietitians
  - Health Educators and Health Coaches
  - Certified Diabetes Educators and Asthma Educators
  - Tobacco Cessation Counselors
  - Community Health Workers
  - Nurses
  - Panel Managers
  - Medical Assistants
- Housing Teams (Support and Services at Home (SASH) for Medicare beneficiaries), funded through CMS Innovation Center; Derived from demand for services, funded by Medicare for largely non-medical functions. First of its kind programs. Key Elements:
  - Person-Centered
  - SASH Staff (1 FTE SASH Coordinator and 0.25 FTE Wellness Nurse for every 100 participants, based in Housing Hub)
  - Volunteers
  - Partnerships with other organizations
  - Information Sharing through Technology

- Prevention and Wellness through Healthy Living Planning and Wellness Programs
- Funded through Blueprint by Center for Medicare and Medicaid Innovation's Multi-Payer Advanced Primary Care Practice Demonstration Project

- SASH Focus Areas:
  - Transitional care interventions
  - Self-management education interventions
  - Coordinated care interventions
- SASH is Multi-Agency Team-Based Care Management

- SASH Provides Participants With:
  - Comprehensive health and wellness assessment and interview
  - Individual Healthy Living Plan
  - Regular check-ins as needed
  - Health and wellness programs
  - Wellness nurse supports
  - Transitions support
  - Medication management assistance
  - Informed team to help in crisis
- Addictions Teams (Support for Medicaid beneficiaries with Opioid Dependence)
  - Hubs: Coordinating Care for People with Complex Addictions and Co-occurring MH/SA Conditions
    - RFP issued to develop 5 regional specialty treatment centers. These centers will provide:
    - All methadone treatment
    - Buprenorphine treatment for more complex patients
    - Consultation for practices providing office-based opiate therapy
  - Spokes: CHT Staffing to Support Patients in Practices that Prescribe Buprenorphine
    - Develop care system ("Health Home") with physician prescribing buprenorphine and collaborating health and addictions professionals

- Monitor treatment adherence
- Coordinate access to supports
- Provide counseling, contingency management, care coordination and case management services
- Participate in regional learning collaboratives

- Medicaid Chronic Care Coordinators
- Results for Patients - Each patient will have:
  - Established medical home
  - Single medication-assisted treatment prescriber
  - Pharmacy home
  - Access to additional CHT resources
  - Access to Hub or Spoke nurses and clinicians
- VCCI's Tiered Approach
  - Beneficiaries with complex health problems receive face-to-face case management from an RN or MSW to coordinate care among providers and connect with other resources in communities and from the state.
  - Beneficiaries at lower risk receive health education and coaching from RNs by phone.
  - The goal is for all VCCI participants to learn to better manage their own health conditions and to work with their health care providers.
- Link to 2012 Annual Report: Read Profile of One Community http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf

Questions

Q: There were three high needs interventions designed into fabric of blueprint – why and what advice do you have for what to pick?

- ***Combination of things – housing folks came to us, with statistics that can blow your mind. (Poverty, cognitive issues, etc.) They felt they were facing HHS issues beyond what they could deal with on a regular basis. They identified the need, but finding the funding stream is another matter. <u>The people I work for, if they hear a good idea, they are going to go for it.</u> On the opioid issue, it was just such a big issue that we felt we had to tackle it. Our next step is to support greater MH integration. Chronic Care is part of Vermont's Medicaid global commitment waiver to provide better care with better costs***
- ***Pick high need populations by sitting in a room together and identifying the gaps in care and what needs are not being met. You can't do it all at once. This program began in one place, but has advanced by picking a series of battle, addressing the needs that bubble to the top and picking one that you think you can make a difference. It's more art than science.***

Q: Where does funding for CHTs come from?

- ***Core teams funded by 5 insurers, treated as almost a public utility. As practices come on board, payments increase.***

Q: Is this just an added cost?

- ***Goal is to save money and provide better care. The pilot communities have been in place since 2008. Based on data in an all payor claims database, VT is Seeing greater than statewide reductions in inpatient care and ED use***

Q: VCCC seems narrowly focused

- ***Yes, goal was to focus it, but change is coming. It was a matter of addressing low hanging fruit***

Q: Why was schizophrenia not on the VCCC list?

- ***It was a decision made based on the needs identified.***

Q: Would you have gotten to where you are with insurer participation without legislation?

- ***There was definitely some desired participation, but there was some pushback as well so the legislative mandate helped.***

Q: How do you think about workforce issues and this new team of providers, shortages, projected retirements, etc. What kinds of training programs and capacity issues did you think about?

- ***Area that was the biggest concern was nursing, though we haven't seen a big problem yet.***
- ***Have interacted with agencies to see about using their staffs, and wellness nurses are often drawn from local home health agencies.***
- ***Just starting to have discussions with community colleges, particularly in area of health coaching.***

Q: SASH seems similar to PSH here in King County, challenge is that services not funded through healthcare dollars but rather local monies. We can't scale these services up to meet the deep demand for them. Does your waiver allow for payment for these services?

- ***Perhaps. SASH works with dual eligible, but scaling up was the conundrum. SASH was a pilot showing great success, but question was how to generalize and expand it. This is where Medicare funding came in to play. The program has grown from 1 team to 26.5 teams, but we have had to slow down a bit, as they have been rolling out faster than funding.***

Robin Henderson

- Strategic Initiative Process
  - We started where our hearts were and then figured out how our work could fit the regulatory requirements
  - COHC started a series of retreats last July
    - COHC set broad expectations ***–Let's make a huge list***
    - Ops Council looked at 38 different options
    - Eight primary initiatives
      - A few sub-initiatives
    - Four system requirements
      - Not all are within our control

    - COHC approved six initiatives going forward
        - Two required more work prior to approval
- Options:
    - Utilization of prior shared savings
    - Grant/Foundation funding
    - Additional State Dollars ($30 million on Governor's Budget)
    - $45 Million CMMI Grant
- Voluntary Assessment of the PM/PM (NOT A TAX)
    - .58% exclusive of the PCPMH –everybody else pays in, even dental bought in
    - All in
- One coordinated plan for health and human services to cover four years, rather than previous 144 plans
- Four Essential Elements
    - Global Budget – stop paying for widget based care, treat the whole person at one time with one payment, and get the value for keeping them healthy
    - Data Analytics and Evaluation
    - Workforce Development – "if you've seen one community health worker, you've seen one"
    - Health Information Exchange ***– we have 15 different EHRs***
- Data Analysis and Utilization – if you can't prove what it is you're doing, you might as well stop. We're not going to change things if you keep doing them the same way all the time
    - Develop common, region-wide metrics
    - Standard data collection protocols and processes
    - Evaluation of improved health outcomes
    - Triple Aim objectives for all initiatives
    - Partnership with Academic Partner
    - Local access to data analysis
    - Common language for research design and implementation
    - Increased access to data for grants and studies
- COHC Initiatives each of these has a work group behind it, comprised of people who work in these areas, and may not be connected to the big seat at the table. Part of the responsibility of the big table is to make sure the little tables are involved as well.
    - Maternal Child Health Three babies averted from NICU covers the $150k hard cost
    - School Based Health Center
    - Behavioral Health/Primary Care Need to build in training for BH folks to communicate with primary care
    - Primary Care in Behavioral Health
    - Chronic Pain Issue has many faces, so they did three different pilots
    - Transitions of Care Aging in place and anything else that addresses these issues will help with the Triple Aim

- Complex Care Coordination Biggest prettiest piece of low hanging fruit on the tree. Must also deal with the precursors to complexity so you can intervene earlier. BridgesHealth is a referral center for the top 1000 most complex patients.
- Pediatric RN Care Coordination Non FQHC has many Medicaid patients – need to jump start with funding an RN
- Integrating Care for Children with Special Healthcare Needs

- This was how we found our community's passion

Question and answer

Q: Is St. Charles the only hospital system in the area?

- ***Yes, but we have 4 CEOs and they still have to get brought together. This issue is simply a barrier, but it just needs to be addressed.***
- ***We have more than 600 providers. 425 are in practices of 15 people or less. We are not Kaiser or GHC so we had to create a virtual network one doc at a time. It's tough, but doable.***

Q: There were nine elements of CCO transformation elements. How do you talk about integrating BH/PC and address diversity and cultural competence?

- ***We created a diversity group across two CCOs to function as a coalition to feed into all of the strategic elements. We have to put diversity in each of the initiatives***.

Next Steps and Close of Morning Session

Judy closed the morning session and invited Transformation Panel members to take a break and come back for a working lunch and the afternoon session.

AFTERNOON SESSION (For Panel Members)

Debrief Morning Session Q&A with Pat and Robin

Judy began the discussion noting that we have to come together and develop a shared language and really pay attention to this.

Q: What does the work we are doing mean for the next 20 years? How do we raise a generation of social workers and medical care providers who speak the language of this morning around wellness and prevention? How do we raise up the language of whole health and make the social determinants more than just buzz words?

Both Robin and Pat spoke of organizing around high cost/high utilizing folks. How do we also wrap in health disparities and social determinants of health?

- ***Pat –Interventions are aimed at high utilizers, but organization around PCMHs means it applies to the whole population, as do the CHTs. The extenders are focused at high***

utilizers. What we have tried to do in VT is to provider barrier free access to care. Who is and who is not getting access to care? It's not a single approach, but a multifaceted approach.

- ***Robin – One of the ways we have dealt with disparities was to keep our county commissioners at the table, as they are the ones looking at the big picture. Early patient in the ED deferral program was a 24 year old woman, living with nine people and couch surfing – she was able to tell her whole story to the community health worker who was able to relate to the challenges she was facing, that traditional healthcare systems don't look at.***

Q: The Flow of people into the system seems very medical centered with people coming in at the doctor level. What might it look like incorporating the human services entry point?

- ***Pat – referrals to CHTs come from all types of sources. Idea is to support PCPs but that is far from the only source of referrals. Patients and families self refer as do many other providers such as community service organizations. Flow has gotten more seamless. Biggest issue is to get together and learn what each other do and that type of education is key to referrals. Community building. We don't mandate much of CHTs, but they do have to meet together with broader community regularly.***
- ***Robin – One of the biggest things we have learned is about relationships. We thought we knew what we all did. Each meeting starts with a patient story. This work was not a series of slam dunks. It requires a lot of behind the scenes battles and negotiations. We all think we are doing and making these connections, but it's not until we come together in a room like this that we really get the benefits of relationships.***

Q: What opportunities do you see now that the ACA has been adopted?

- ***Pat – We've seen many benefits through the demonstration projects of CMS. Medicare is very much at the table. They have been terrific to work with – very unexpected of a federal bureaucracy – innovative. VT had many of the ACA reforms already in place, but the ACA has been invaluable.***
- ***Robin – How many hospital reps are here? How many hospitals are here? The ACA brings forward things hospitals need to do and change – readmissions – they can't solve these problems themselves. They will be penalized for many different things, which means you have many ways to engage the hospitals with health and human services. Hospital funding system will change. If they are not reaching out to you now, keep reaching out to them to help them understand what they have to gain by being at your table.***

Creating an Inclusive and Innovative System of Care

Yesterday, Today and Tomorrow – Betsy Jones

Betsy Jones provided an overview of the evolution of care systems and the topic of where we want our system to be. She noted that the collective energy of our community, along with the levers we have available like federal opportunities will bring our system to the state we want it. Her slide presentation focused on where we were, where we are today, and where we would like to be. In the future, the focus

is a healthy population with a higher life expectancy proportionally throughout King County. Rather than dictating the exact service delivery, let's figure out the outcomes and be creative within our communities. Think about social determinants for everyone and areas in which we want to level the playing field.

- Yesterday v. 1.0
    - Sick care focus: little $ for prevention & early intervention
    - Uncoordinated care
    - Lack of integration (silos of excellence)
    - Minimal reporting of quality and outcomes
    - Pay for volume
    - Minimal transparency
    - Bifurcation: Health-Human Services
- Today v. 2.0
    - Shift $ further upstream: prevention & early intervention
    - High impact strategies (medical homes, chronic disease focus, housing first, care management, etc.)
    - Minimal integration
    - Initial reporting of quality & outcomes
    - Pay for volume with bonus layer
    - Initial transparency
    - Beginning integration activities
- Tomorrow v. 3.0
    - Health of the individual requires a healthy community; greater focus on social determinants of health
    - Healthy population centered; further shift of $ upstream
    - Seamless integration of all services & supports (one care plan, one virtual care team)
    - Robust reporting of quality and outcomes
    - Pay for value (outcomes)
    - High transparency
    - Seamless integration of health and human services

Draft System Design Ideas – Dale Jarvis

Sample Vision: Safe, healthy individuals, families and communities.

Triple Aim Goals: Better Health, Better Care, Better Costs.

Important Definition: ***Care:*** The provision of what is necessary for the health, welfare, maintenance, and protection of someone or something

Sample Outcomes

- **By 2023, every <u>individual and family</u> living in King County will have:**
    - Adequate health coverage that addresses their whole health needs.

- Care to be as physically and mentally fit as possible.
- Knowledge, skills, confidence, support systems, and technology to manage their own health and care.
- Access to affordable, healthy, local food.
- Supportive relationships within families, neighborhoods, and communities.
- Quality education and early childhood development.
- Family wage jobs and job training.
- Affordable, safe, quality housing.

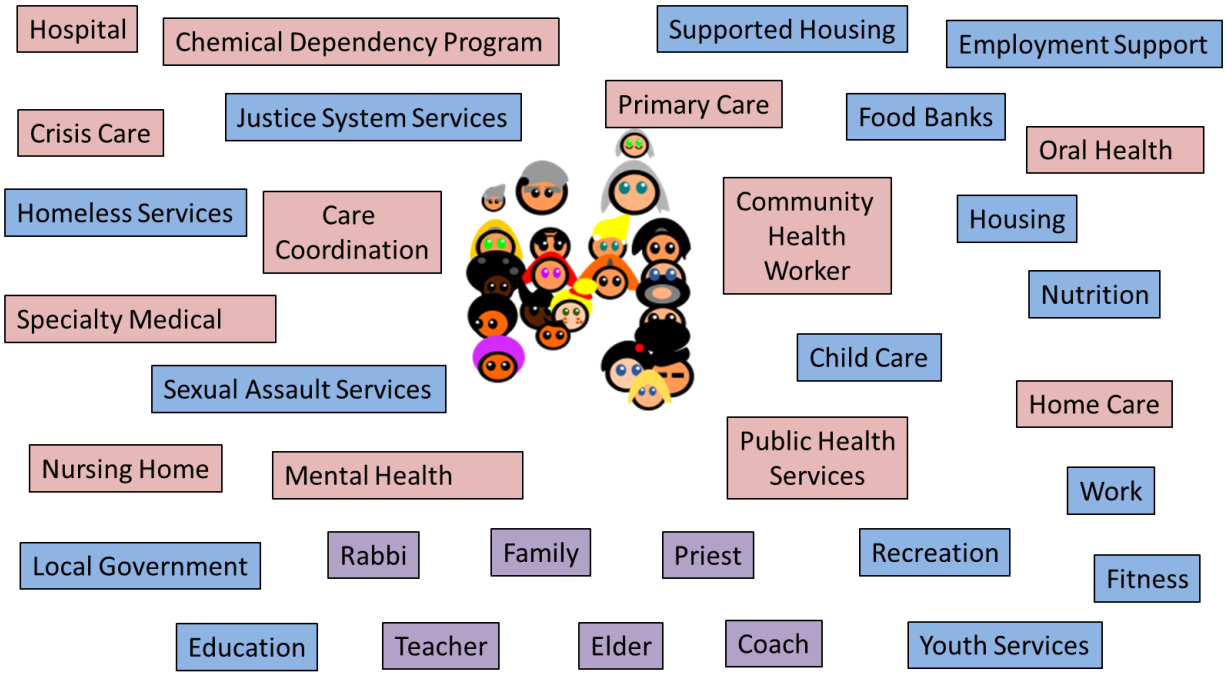
- **By 2023, King County <u>health and human services providers</u> will be:**

  - Part of an integrated, accountable and transparent system of care.
  - Reimbursed through a payment for value (not volume) model that supports the provision of effective and efficient services.
  - Providing person-centered, culturally competent, high quality, evidence-informed services.
  - Actively using electronic health and human service records connected through a *smart* health and human service information exchange.

- **By 2023, every <u>community</u> in King County will have:**

  - Wide availability of healthy foods, transportation options, and safe housing.
  - Adequate parks and other safe places to play and exercise.
  - Protections from exposure to environmental irritants and pollutants.
  - Low rates of poor health behaviors.
  - Low mortality and morbidity rates.
  - Low unemployment and high educational attainment.
  - The health of an individual requires a healthy community.

The Necessary Ingredients



Accountable Care Community (ACC):

"a collaborative, integrated, and measurable multi-institutional approach that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services, and healthcare delivery. The ultimate goal of the ACC is a healthier community."

- Organizing the necessary ingredients into Accountable Care Communities
  - The Vermont Model
    - In this model, the Community Teams are at the center of the Accountable Care Community (ACC) serving as the lead care coordination entity.
    - All care providers are part of the Accountable Care Community, supporting the integration of care into a single care plan for each individual and family that chooses to use that particular ACC.
  - The Atlanta Model
    - In this model, a One-Stop Health and Wellness Center/ Medical-Health Home serves as the *Hub* of the Accountable Care Community (ACC) serving as the lead care coordination entity.
    - There are required anchor tenants; probably primary care with mental health, chemical dependency and oral health.
    - Care providers not located at the Hub are the Spokes of the ACC, supporting the integration of care into a single care plan for each individual and family that chooses to use that particular ACC.

- The Missouri Model
    - In this model, a One-Stop Health and Wellness Center/ Medical-Health Home serves as the *Hub* of the Accountable Care Community (ACC) serving as the lead care coordination entity.
    - There are required anchor tenants; probably primary care with mental health, chemical dependency and oral health.
    - Care providers not located at the Hub are the Spokes of the ACC, supporting the integration of care into a single care plan for each individual and family that chooses to use that particular ACC.
- The Google Model
    - In this model, the Hub of the Accountable Care Community (ACC) is virtual via the electronic health record and all care coordination is decentralized.
    - All Care providers are Spokes of the Accountable Care Community, supporting the integration of care into a single care plan for each individual and family that chooses to use that particular ACC.

- Much work to come
    - The Collective Impact work has taught us that Accountable Care Communities require a *backbone organization* to provide necessary infrastructure to support success. But let's not get ahead of ourselves; this work comes in later sessions.
    - If the Transformation Plan works as it should, local, state and federal funders/payors (private and public), will be supporting community-based efforts to create Accountable Care Communities that are customized to meet the needs of the different communities in the County.
    - Note that a community can be a specific geographic neighborhood or a more virtual, population-based community.
    - We know that these types of integrated and accountable systems of care don't crop up overnight; that they should be multi-phase, community-driven efforts that are grounded in a set of guiding principles, evolving over time.
    - Testing out whether there are elements of any or all of these models that might be applicable to the creation of King County Accountable Care Communities.

Questions and Answers

Q: Process question – what's next?

- ***Small group exercise to work with the models***

Q: You joked about not doing an RFP right away, is part of what's to come an RFP that is part of the transformation process. There are concerns that the application process needs definition as do the review and design panel of the RFP process.

- ***Yes, and that will be part of the design work we are creating.***

Q: The models all have the same components, but with a different center. What are we supposed to be paying attention to? Is that the main difference?

- ***Yes, and much more! This is part of the process of the small group exercise.***

Q: Concern that there are some people who are not getting any care currently.

- ***What we are attempting to do with this plan is to create an anti-fragmentation design to leverage additional revenues and recognizes the social determinants of health, is community grown, and flexible.***

Q: Concern that care coordination and data collection also be cognizant of privacy rights.

- ***Concern about choice in services. One stop shop vs. no wrong door, and need to serve people where they are when they need care (may live one spot and work elsewhere the majority of the time).***

Small groups followed by reporting out

Small Group Exercise Setup

Each group/table represents an Accountable Care Community Design Work Group that will be responding to service delivery system portions of Motion 13768:

> *A motion requesting the executive, in collaboration with the departments of public health and community and human services, and a community stakeholder panel informed by local and national expertise, to develop and submit for council review and approval a plan for an accountable and integrated system of health, human services and community based prevention in King County.*
>
> *The development of the plan should recognize the various populations and diversity of those in need (of) services throughout the county…*
>
> *The plan should be individual, family and community centered and should provide for culturally appropriate, evidence-based or evidence-informed strategies…*
>
> *…the plan should address… options for the creation and implementation of a single point of accountability for health and human services cost, quality and outcomes.*

Exercise Objective: Develop an initial set of design ideas for a King County Accountable Care Community.

Exercise Steps

Step 1: Introduce yourself to the other members of your small group.

Step 2: Identify a facilitator and recorder (who will be handing their notes in).

Step 3: Take 5 minutes to individually read the "15 things to know about your hypothetical community" (See Appendix 1).

Step 4: As a group, take 5 minutes to decide what additional "things to know" about your hypothetical community are important to support your design work.

Step 5: Thinking about everything you heard today, begin designing your Accountable Care Community, using the following questions to assist your effort:

- What ACC organizing structure (Vermont, Atlanta, Missouri, Google, or Other) would serve your hypothetical community best? Make a drawing, editing and adding more detail to the relevant model.
- What are the High Impact Interventions from slide 15 that you want to prioritize for Years 1-2 of your ACC in order to move toward the Triple Aim?
- What's your strategy for achieving seamless integration of all services & supports (one care plan, one virtual care team)?

A Core Team member will be at each table and Robin and Pat will be roaming. Feel free to grab them for a question.

Summary of Work

Additional Things to Know	Model Selected	Interventions	Strategies	Notes
• Groups generally wanted additional detail about the population demographics and characteristics as well as other potential disparities	• Groups tended to not fully embrace any one model, but seemed drawn to aspects of the Vermont and Missouri models, and generally rejected the Google Model (largely on privacy concerns).	• Groups generally agreed that the high impact interventions all had merit and tended to prioritize Community Health (Care) Teams, PCMH, and Complex Case Management.	• There was broad agreement for the need for extensive stakeholder outreach and engagement, with recognition that moving toward many of the interventions would inherently bring greater collaboration.	• Privacy was a frequent concern as was the need to be sure that models and designs were not overly "clinical" and that any governance structure be founded on deep local input and control.

Details of Work

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
Group One • Heidi Albritton, Seattle Human Services • Shelley Cooper Ashford, Center for Multicultural Health • Colleen Brandt-Schluter, City of Sea Tac, Human Services • David Downing, Youth Eastside Services • Jane Beyer (or Dan	• LTC • Data gaps, i.e., access to fresh local food • Importance of outreach and need to push services out, rather than just pulling people in • Culturally competent care as part of design; Role of place based design • Prefer to have both	• Vermont ○ CHTs very appealing • Discussion of governing body and coordination so that it is a partner, and not command and control. *Learned this was built into the grant process in VT.* What is the organizing structure around community teams? How is that coordinated and what is the centralization of that efforts ○ Accountability, transparency, and	• CHTs • Complex care management • Housing first • Prevention early intervention • Hot spotting • ***Built Environment***	• Infrastructure designing governance structure to support goals & accountability, agility (inclusivity/ egalitarian) • Build community health teams • Designing/ mandating outcomes (let the community decide how to get there), what is supporting/funding	• Model discussion focused more on the conceptual than clinical • Assumed we were talking about KC. • Local flexibility, but accountability as a whole • Important to design governance; in the community and not from the top down

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
Murphy), DSHS • Betsy Jones, King County Executive's Office	geographic and population-based programming and services	diversity need to be included in agreements		role of governance structure? Local flexibility but accountability as a whole. Results are conditions of well-being.	
Group Two • ~~Lisa Cohen, Washington Global Health Alliance~~ • Merril Cousin, KC Coalition Against Domestic Violence • ~~Deanna Dawson, Sound Cities~~ • Doreen Booth • Diane Sosne, SEIU Healthcare 1199NW • Terry Pottmeyer, Friends of Youth • Michael Gedeon, King County Executive's Office	• Need statistics on youth: ○ Smoking ○ Obesity ○ One or more chronic conditions ○ Diagnosed with mental disorder ○ Drug/alcohol addiction • Educational attainment • Geographic nature of community (City, rural) • % undocumented	• Vermont, with elements of MO • Like centralized coordinating entity, but without mandate that it be physical. Physical colocation might depend on what's already in the community. • People need to always have option, with coordinating entity providing linkages, but circles would not be limited to only referrals from within. Goal was to allow people and providers to serve/be served when and where needed. • Every person needs information that they can access any or all services.	• Noted that while 4 may be too many for first years, but these seemed important • CHT • Complex Care Mgmt • PCMH • School Clinics	• Regular meetings – navigator and high impact interventions. • Need for knowledge sharing between providers of high impact interventions • Intensive community engagement process. Need for something like the SeaTac Global to Local project to go in to people's homes	
Group Three • Kelly Rider, Housing Development Consortium	• As others discussed, plus detail about the 2/3 of children/ youth	• Struggled with model • Rejected Google • Settled on cross of VT and MO (with concerns about	• Wanted all of them CCT/CHTs seemed most important • Touched on the others;	• Build around/ recognize there are multiple communities in KC	• Want local control over the design of the CCTs with oversight of those

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
• Julie Lindberg, Molina Healthcare of Washington • Sara Levin, United Way of King County • Tizzy Bennett, Seattle Children's • Janet St. Clair, Asian Counseling and Referral Service • Susan McLaughlin, King Cty Dept. of Community and Human Services	with ACEs and what they were • What's the population - is it a food desert? What is primary care access and hospital availability? ○ % taking Medicaid • Transportation options / transit dependence • Geographic spread • Languages spoken • Cultural, racial, ethnic, immigrant, refugee breakdown • Percentage of Medicaid to Private Insurance • Need calculation of human services types and who they are	MO brick and mortar issues) • Like idea of multiple "hubs" to be able to address key barriers (including geography and language) • Consensus on CHTs but call them Community Care Team • Model needs to be 3 dimensional • Need local control of design of teams to have flexibility to adapt to needs of community, but with oversight to meet the outcomes	couldn't decide where to start after the CCTs PEI • PCMH • School based clinics/***Services*** • Wellness programs • Complex care management	• Better integration to increase capacity (r is that an incorrect assumption?) • Local control over design of community care team and identifying problem and resources, **BUT** need to be sure equity is kept to top of mind and built in to strategies • Combine PCMH and Care teams/ Chronic care management • Prevention and wellness integration	teams to ensure that they are meeting the outcomes of the system
Group Four • Jim Blanchard, Auburn Youth Resources • Bill Hallerman, Catholic Community Services	• Needed to know what service system looks like – who are the current providers? • Demographics of racial and ethnic details.	• Could not come up with a model it felt that there might be models that would be better if we're going to drive money out of healthcare and increase the money for prevention and human services.	• All high impact interventions are important. • Hot spotting. PEI, Housing first, Justice Diversion. • Hard to sort out which to use and which to	• Hot spotting – geographic locations/place based is a key strategy • PEI – looking at where people spend their days, how to	Fundamental issue is that the models are care management oriented and don't address prevention and public health robustly

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
• Dr. Jeff Harris, Health Promotion Research Center • Ron Jackson, Evergreen Treatment Services • Margaret-Lee Thompson, Community Member • Janna Wilson, Public Health Seattle & King County • ***Daniel Malone, DESC -- Guest***	• % of residents with special needs. • Who are the predominant employers? • Who is in the surrounding communities? • Transportation options? • # homeless in the area? • Justice is an important piece	• They imply a case management model that may not be desirable in era of HCR. May want to think more about a PEI model.	discard.	increase resources where people are. Take a "society wide" view • Housing first • All these elements are important, just a question of where you put the emphasis	
Group Five • Hyeok Kim, Interim Community Development Association • Brian Knowles, Bailey Boushay House • Emily Leslie, City of Bellevue • Dr. Dan Lessler, Harborview Medical Center • Patricia Hayden, Seattle-King County YWCA • Kelli Carroll, King	• Needed to understand linguistic diversity and what does racial, ethnic, and geographic disparities, as well as poverty levels • Wanted to understand where dollars were spent – MH/SU? Inpatient? Pharma? • Any information about how many of the 86k could not access care	• MO, with a bit more virtual. • Confidentiality was a big issue • In relationship to models – Missouri and virtual models combined. There was question in relationship to privacy	• CHT • Com svcs • Hot spotting • Housing first • PCMH • ***Privacy and tech needs to be addressed***	• Need to have many discussions with stakeholders • Need for phased strategies • Need more people of color in stakeholder discussions • Need for one care manager/ coordinator and need for mutual information sharing. • Phased approach and large amounts of community participation, more	

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
County Council • ***Sharyne Shiu Thornton*** • ***Colleen Kelly*** • ***Julia***	• Graduation rates • Educational metrics • % of foster children and kinship care • Fund for human services • How do numbers compare to others in state? • Measure of homelessness • Measure of incarceration			people of color need to be involved. One care manager/ coordinator – not sure how but did recognize that information sharing needed to happen.	
Group Six • Marilyn Mason-Plunkett, Hopelink • Nathan Phillips, South King Council of Human Services • Adrienne Quinn, Medina Foundation • Mark Secord, Neighborcare • Mark Okazaki, Neighborhood House • Karen Spoelman, King County Community and Human Services		• Combination of Atlanta and MO • Needed to be focused on small geographic area to build relationships in community to identify who needs help AND to build trust • Discussion of school being a hub, as a physical location, but with others as well (PSH) Need other physical locations: permanent supported housing for chronically homeless folks; any other populations not touching schools. • Need to map the capacities		**Discussion:** How about a model of a "communal garden" with commitment by partners over several years/share common resources/reap different harvests in different years, but it's all valued and a part of the larger plan. **Metaphor:** Design a Communal garden, but with a central master gardener—perhaps the County's role in the middle of the circle??) County can help build capacity to ensure a	• Begin with high medical users – hot spot for diabetes, for instance • Some mismatch of restrictive, narrow funding and need to change and recognize that funding needs to be flexible and long term oriented to build the system. Need agreement among various funders to have MOUs among layers of government on outcomes. Money

Group	Additional Things to Know	Model Selected	Interventions	Strategies	Notes
		in a geographic area acknowledging the capacity disparities; need to build out some more than other.		minimum set of assets in each community. Need a high level county strategic vision. Then individual communities can pick issues they wish to address	would be generated through wrapping care, uniform outcomes, remove duplication of care managers. • In human service field, need to cut down compliance cost with uniform outcomes. • Some families are better at accessing care than others

Public Comment Opportunity

Daniel Malone, DESC – Mr. Malone noted that he is discombobulated by the assumption that we need to think about integrating what we currently have. Are we working from the assumption that the lack of capacity issues are in scope or out of scope for this conversation. If we do this right, we will have more capacity in an integrated system with better management to shift dollars into more needed services.

Human services are largely inadequate for the scale we need. A disproportionate amount of funding is going to some services and activities based on proportion of overall population. I want to be part of a process that makes sure system is right sized overall, rather than just case management

Response – Are capacity issues in scope or out of scope? They are both. We believe that if we do this right, we will get more capacity by spending our dollars more wisely on PEI and better management of the 10% to shift dollars into other services. Can't assume that the capacity is there.

We have new resources coming in for the Exchange and Medicaid. Many groups focused on healthcare. At least at the local level, could we look further upstream like early childhood education. Is it a given that we have to go with FFS or could we talk about prospective payment? Current model is not sustainable.

Judy asked, how do we want this to work for the people in this county? There are county and state issues and the process does not need to tinker with status quo but rather should look at what we can do to achieve the triple aim goals.

Dale noted that there are other pieces that we need to tackle for Accountable Care Community Design:

- Finance
- Facilities
- Performance & Outcome Measurement
- Policy & Governance
- Single Care Plan
- Virtual Care Team
- Quality Improvement
- Technology

It was also noted that we already have many one stop like services, but issue is how we coordinate the various one stops to meet the needs of all and bring the systems together.

Meeting Wrap Up

The next meeting is March 20th from 1-4 PM, also at Mercerview.

There will be a survey about today's meeting and please send any feedback to Susan McLaughlin.

Final words from Pat – just keep working hard at this. It's messy hard work, but keep working together and think always about what's best for the residents of your community.

Appendix: 15 Things to Know About Your Hypothetical Community (Small Group Exercise)

1. 81,397 members of your community; note that we're using a geographic community for this exercise.
2. $522 million was spent on healthcare last year ($6,782 per person).
3. We are still calculating how much was spent on human services.
4. Mix of age groups with a significant numbers of preschoolers, school-age children, transition-age youth, adults, aging baby boomers (who don't think of themselves as senior citizens), and senior citizens.
5. Culturally, ethnically, racially diverse.
6. Mix of incomes with 33% of children participating in the National School Lunch Program (low-cost or free lunches).
7. 12% of the community is uninsured and more than half of this group will be eligible for Medicaid or coverage through the Exchange with a subsidy.
8. Two-thirds of the community has experienced one or more Adverse Childhood Experiences (ACEs) before age 18 and one in five had five or more ACEs.
9. 13% of adults smoke.
10. 22% of adults are obese.
11. 45% of adults have one or more chronic health condition.
12. 30% of adults have a diagnosable mental health disorder.
13. 15% of adults have a drug/alcohol addiction or dependence.
14. Unemployment, violent crime, and excessive drinking are all above the state average.
15. There are twice as many fast food restaurants in your community than the national avg.